

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. H.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33815

FILED OCT 17 1944

Registration District No. 14

Primary Registration District No. 3007

Registrar's No. 503

1. PLACE OF DEATH:

(a) County Butler
 (b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Poplar Bluff Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 days
(Specify whether years, months or days)
 In this community 8 days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Carter
 (c) City or town Fremont
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A? 1 years.

3. (a) PRINT FULL NAME Fannie M Green

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
 6. (a) Single, widowed, married, divorced Divorced
 6. (b) Name of husband or wife George W. Green 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan 24 1878
(Month) (Day) (Year)

8. AGE: Years 68 Months 7 Days 17 If less than one day hr. _____ min. _____

9. Birthplace Shannonco mo
(City, town, or county) (State or foreign country)

10. Usual occupation House keeper

11. Industry or business _____

MOTHER FATHER { 12. Name William Barnes
 13. Birthplace USA
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Rockman
 16. Birthplace USA
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Fred O. Green
 (b) Address Fremont mo

17. (a) Normal (b) Date thereof (Month) (Day) (Year)
 (c) Place: burial or cremation Eveline

18. (a) Signature of funeral director Seaton Perwith
 (b) Address Van Buren mo

19. (a) 9-21-44 (b) Belle Kimmel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 21
 year 1944 hour 11:15 minute a M.

21. I hereby certify that I attended the deceased from Sept 12 1944
 to Sept 21 1944

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Cancer of Lung & Bladder
Metastasis - Metastasis

Due to _____

Due to _____

Other conditions: 468
(Include pregnancy within 3 months of death)

Major findings: 468
 Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (e) Means of injury?

23. Signature Charles H. H. [unclear]
 Address Poplar Bluff Mo Date signed 9/21/44

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 1044-134

Date Filed 10-11-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 303

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:.....
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Fannie M. Green

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER
12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a) Burial (b) Date thereof 9-24-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....
18. (a) Signature of funeral director Leaton Peurich
(b) Address Law Bureau mo.

19. (a) 9-30-44 (b) Belle Neune
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day..... year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....; that I last saw him..... alive on..... 19.....; and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....
Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

33813